MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 L

09342

CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

(I)

1. PLACE OF DEATH:

County St. Marys

City or town Morganza (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town Morganza

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME James Bennett

3.(b) Social Security Number —

4. Sex: male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Nancy A. Bennett

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): 7 1881

8. AGE: Years: 66 Months: Days: If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER

12. Name: James A. Bennett

13. Birthplace: Maryland

MOTHER

14. Maiden name: Margaret Price

15. Birthplace: Maryland

16. Informant: Nancy A. Bennett

Address: Morganza, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-14-47 (month) (day) (year)

Cemetery or crematory: Galilee Cemetery

Location: Oakville Md.

18. Funeral director: C. B. Robinson

Address: Leonardtown Md.

19. 10/13 1947 (Date received by registrar) Casmalier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 1947 at 1:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 4 1947 to Oct 11 1947 and that I last saw him alive on Oct 6 1947

	DURATION
Immediate cause of death: Chronic Nephritis	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE James A. Carmelin M. D. or other

Address Leonardtown Date signed 10/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47d

09343

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:

County: St Marys

City or town: Leonardstown Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Days

Hospital, institution, or street address where death occurred: St Marys Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: St Marys

City or town: Dept Bunnie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: John Thomas Bennett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Lillian Stevens Bennett

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Dec 24 - 1895

8. AGE:

Years	Months	Days	If less than one day
51	9	9	....hrs. ....min.

9. Birthplace: Cal St Marys Md (Town, county, and state)

10. Usual occupation: Traffic Manager

11. Industry or business:

FATHER — 12. Name: William L. Bennett

13. Birthplace: St marys Co Md

MOTHER — 14. Maiden name: Margaret E. Abrahamsen

15. Birthplace: St marys Co Md

16. Informant: Mrs Myrtle F. Bennett

Address: California Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Oct 7 - 1947 (month) (day) (year)

Cemetery or crematory: Ebenezer Cemetery

Location: California Maryland

18. Funeral director: W. C. Mattingley Sons

Address: Leonardtown Md

19. Oct. 6 - 1947 (Date rec'd by registrar) P. J. Beary MD Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 4 1947, at 2:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1946 to Oct 4 1947

and that I last saw him alive on Oct 3, 1947

Immediate cause of death	DURATION
Carcinoma of Lung	1 year
Due to	
Due to	
Other conditions Asthma	4 months

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: P. J. Beary M.D. M. D. or other

Address: Great Mills, Md. Date signed 10-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

09344

CERTIFICATE OF DEATH

Reg. Diat. No. 281

1. PLACE OF DEATH:

County St. Mary's

City or town Rural, Hermansville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's

City or town Rural, Hermansville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Infant Berry

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-11-47

8. AGE: Years — Months — Days — If less than one day — hrs. 10 min.

9. Birthplace Hermansville, Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name James Berry

FATHER 13. Birthplace Oakville, Md.

MOTHER 14. Maiden name Mary L. Mudd

MOTHER 15. Birthplace California, Md.

16. Informant James Berry

Address Hermansville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-11-47 (month) (day) (year)

Cemetery or crematory St. Aloysius

Location Leonardtown, Md.

18. Funeral director James Berry

Address Hermansville, Md.

19. 10-11-1947 (Date rec'd by registrar) P. J. Beam M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1947 at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Delivered by midwife Oct. 11 1947

and that I last saw h alive on 19

Immediate cause of death	DURATION
Premature birth	2½ mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. J. Beam M.D. M. D. or other

Address Great Mills, Md. Date signed 10-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45


RECEIVED
OCT 14 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

117a

09345

CERTIFICATE OF DEATH

Reg. Diat. No. 282

1. PLACE OF DEATH:
County St. Marys
City or town Hollywood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County St. Marys
City or town Hollywood
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME James J. Butler

3.(b) Social Security Number —

4. Sex: male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Annie M.
6.(c) If alive, give age: 39 years
7. Birth date of deceased (mo., day, yr.): May 8, 1904
8. AGE: Years: 43 Months: Days: If less than one day: hrs. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Richard Thomas
13. Birthplace: Maryland
MOTHER 14. Maiden name: Matilda Butler
15. Birthplace: Maryland
16. Informant: Annie M. Butler
Address: Hollywood, Md.
17. Burial (Burial, cremation, or removal (Which?)) Date thereof 10-4-47 (month) (day) (year)
Cemetery or crematory: St. Johns
Location: Hollywood
18. Funeral director: R B Robinson
Address: Leonardtown
19. 10/3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1947 at 6:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 1947 to Oct 2 1947
and that I last saw him alive on Oct 1, 1947
Immediate cause of death: Gastric Ulcer (Perforated)

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph A. Carnaline M. D. or other
Address Leonardtown Date signed 10/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09346

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 284

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: St Marys Co. Md.
City or town: Near Ingersharnesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Died with daughter
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: St Marys
City or town: Near Chaptico
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lizzie Edwards

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Widow

6.(b) Name of husband or wife: Lee Edwards
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1871

8. AGE:

Years	Months	Days	If less than one day
76	7	—	..... hrs. ..... min.

9. Birthplace: Near Chaptico (Town, county, and state)
10. Usual occupation: Farmers wife
11. Industry or business
FATHER 12. Name: ~~Nellie Cole~~ David Burns
13. Birthplace: Chaptico
MOTHER 14. Maiden name: Nellie Cole
15. Birthplace: Chaptico
16. Informant: Ignatius Butler (Son)
Address: Chaptico
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 11 '47 (month) (day) (year)
Cemetery or crematory: St Josephs Cemetery
Location: Near Morganza Md
18. Funeral director: Rose E. Weldy
Address: Chaptico Md.
19. Oct 11 1947 (Date rec'd by registrar) Eleanor S. Canter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9 1947 at 10 00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7 1947, to October 9 1947
and that I last saw her alive on October 7 1947

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE - RIGHT	5 days
Due to GENERALIZED ARTERIO-SCLEROSIS	UNKNOWN
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op. —
Autopsy results: NONE
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John H. Griffin M. D.
M.D. or other
Address: Hughesville Date signed Oct. 10, 1947

Evidence for the change of father's name is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09347

FILM No. G 113 NOV 28 1947

CERTIFICATE OF DEATH

Reg. Diat. No. 262

1. PLACE OF DEATH:

County: St. Mary's County

City or town: Patuxent River, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? None-Accidental Death.

Hospital, Institution, or street address where death occurred:
None

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Nebraska County: Nuckolls

City or town: Superior
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1207 Idaho St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME
ELLISON, Wayne Winter

3.(b) Social Security Number
507-07-3436

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jane Beverly Lundquist

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): 9 December, 1919

8. AGE: Years	Months	Days	If less than one day
27	9	23	hrs. min.

9. Birthplace: Superior, Nebraska
(Town, county, and state)

10. Usual occupation: Officer (Lieutenant Commander)

11. Industry or business: U.S. Navy

FATHER
12. Name: Wayne Winter Ellison Raymond John

13. Birthplace: Lodi, Nebraska

MOTHER
14. Maiden name: Ethel Winter

15. Birthplace: Lodi, Nebraska

16. Informant: U.S. Navy records

Address

17. Transportation
(Burial, cremation, or removal. Which?) Date thereof: 10-7-47 (month) (day) (year)

Cemetery or crematory: Evergreens

Location: Superior Nebraska.

18. Funeral director: P.B. Robinson

Address: Leonardtown Md.

19. 10/7 47 Carmalee
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 October 1947 at 10:07 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Not attended. 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
1. Injuries, Multiple Extreme	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 30 Oct. 47

Where did injury occur? St Mary's County, Maryland
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Chesapeake Bay

Means of injury: Aircraft Accident Injured at work? Yes

23. SIGNATURE: Paul Vaughan PAUL VAUGHAN Capt. MC USN
Julian S. Lane (M.D.) M. D. or other

Address: U.S.N.A.S. PATUXENT River, Md Date signed: 10/6/47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09348

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

119a

CERTIFICATE OF DEATH

Reg. Dist. No. 2-56

1. PLACE OF DEATH:
County: St. Marys
City or town: Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One hour
Hospital, institution, or street address where death occurred:
St. Marys Hospital - Leonardtown Md
How long in hospital or institution? One Hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: St. Marys
City or town: Rural Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alice Helena Heggs

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Infant

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 31 - 1946

8. AGE: Years: One | Months: 2 | Days: 9 | If less than one day: ..... hrs. ..... min.

9. Birthplace: St. Marys County Md
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Fredrick Cleveland Heggs
13. Birthplace: St. Mary's Co. Md

MOTHER
14. Maiden name: Mary Catherine Vanwert
15. Birthplace: St. Marys Co. Md

16. Informant: Mrs. M. C. Heggs
Address: Maddox Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/01/47 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: Bushwood Md

18. Funeral director: Rose E. Welch
Address: Chaptico, Maryland

19. 10 - 1 - 0 1947 (Date rec'd by registrar) N. B. Calvert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 1947, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 9 1947, to Oct 10 1947 and that I last saw her alive on Oct 9 1947

	DURATION
Immediate cause of death: Convulsions	
Due to: Acute Gastro-intestinal infection	10/9/47
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: none — Date of op.

Autopsy results: none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Aloysius C Weld M.D.
M. D. or other
Address: Chaptico Md Date signed 10/10/47

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09349

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 2-62

1. PLACE OF DEATH:

County: St Marys

City or town: Morganza Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: St Marys

City or town: Morganza
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Alexander Johnson

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary A. Johnson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 28 1861

8. AGE: Years	Months	Days	If less than one day
85	9	6	..... hrs. ..... min.

9. Birthplace: Leonardtown St Marys Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: farm

FATHER
12. Name: Joseph Johnson
13. Birthplace: St Marys Co

MOTHER
14. Maiden name: Mary E. Mattingley
15. Birthplace: St Marys Co

16. Informant: J. C. Johnson
Address: Morganza Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 6 1947 (month) (day) (year)

Cemetery or crematory: St Josephs

Location: Morganza Maryland

18. Funeral director: W C Mattingley Sons

Address: Leonardtown Maryland

19. 10/3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 3 1947, at 5.05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to Oct 3 1947 and that I last saw him alive on Sept 30 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank A. Camalier M. D. or other

Address: Leonardtown Date signed 10/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09350

Reg. Diat. No. 282

1. PLACE OF DEATH:

County: St Marys

City or town: Laurel Grove Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: St Marys

City or town: Laurel Grove
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #1 Mechanicsville Md
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Blanche M. Lee

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: J. K. Lee

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): Sept 30 - 1869

8. AGE: Years: 78 | Months: | Days: 16 | If less than one day: ...hrs. ...min.

9. Birthplace: Laurel Grove St Marys Md
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Farm

FATHER
12. Name: Joseph Curry
13. Birthplace: St marys Co

MOTHER
14. Maiden name: Martha Hill
15. Birthplace: St Marys Co

16. Informant: J. K. Lee
Address: Mechanicsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct-19-1947 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location: Laurel Grove Md

18. Funeral director: W. C. Mattingly Sons

Address: Leonardtown Maryland

19. 10/18/47 (Date rec'd by registrar) Candelay Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 16 1947 at 7.00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10th 1947 to Oct 16 1947 and that I last saw h.. alive on Oct 14 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	6 hrs
Due to: Arterio Sclerosis	Long time
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Francis J Greenwell Md
M. D. or other

Address: Leonardtown Md Date signed 10-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. 'Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

09351

131a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 282

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: St Marys

City or town: Loveville Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
Loveville Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: St Marys

City or town: Loveville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph Fredrick Long

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mary L. Johnson Long

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): June 6 - 1865

8. AGE: Years	Months	Days	If less than one day
82	4	25	hrs. min.

9. Birthplace: Loveville St Marys Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farmer

FATHER
12. Name: Henery Long
13. Birthplace: St Marys Co

MOTHER
14. Maiden name: Sallie Bennett
15. Birthplace: St Marys Co

16. Informant: Mr John Long

Address: Loveville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 3-1947 (mooth) (day) (year)

Cemetery or crematory: St Joseph Cemetary

Location: Morganza Maryland

18. Funeral director: W C. Maddingley Sons

Address: Leonardtown Maryland

19. Nov 1 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 30 19 47 at 12.05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 47 to Oct 30 19 47 and that I last saw h[illegible] alive on Oct 30 19 47

Immediate cause of death	DURATION
Chronic Myocarditis	
Generalized Arteriosclerosis	
Due to: Old Age	
Due to: -	
Other conditions: Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Odysseus A Welch M D
M. D. or other

Address: Chaptico Md Date signed: 10/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

09352

CERTIFICATE OF DEATH

Reg. Dist. No. 284

1. PLACE OF DEATH:

County ...

City or town ... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ...

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? ...

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ... County ...

City or town ... (If outside city or town limits, write RURAL and give nearest town)

Street No. ... (If rural, give LOCATION)

2.(a) If veteran, name war ...

3.(a) FULL NAME

Mill

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife ...

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 10-5-47

8. AGE: Years ... Months ... Days ... If less than one day ... hrs. ... min.

9. Birthplace ... (Town, county, and state)

10. Usual occupation ...

11. Industry or business ...

FATHER 12. Name ...

FATHER 13. Birthplace ...

MOTHER 14. Maiden name ...

MOTHER 15. Birthplace ...

16. Informant ...

Address ...

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 6 47 (month) (day) (year)

Cemetery or crematory ...

Location ...

18. Funeral director ...

Address ...

19. 10-6-47 (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5-47 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive on 10-5- 19 47

Immediate cause of death	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...

Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE ... M. D. or other

Address ... Date signed 10-6-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09353

CERTIFICATE OF DEATH

Reg. Dist. No. 2 8 4

1. PLACE OF DEATH:

County St. Mary's

City or town Rural Avenue

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County St. Mary's

City or town Rural Avenue

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Susan Morgan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	W	widowed

B.(b) Name of husband or wife James Morgan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8-13-1862

8. AGE: Years	Months	Days	If less than one day
85	2	5	..... hrs. ..... min.

9. Birthplace Wicomico, St. Mary's, Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Andrew Jackson Thompson

13. Birthplace Wicomico, Md.

MOTHER 14. Maiden name Susan Matilda Morgan

15. Birthplace Wicomico, Md.

16. Informant Garnett Thompson

Address Bushwood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-21-47 (month) (day) (year)

Cemetery or crematory Sacred Heart

Location Bushwood, Md.

18. Funeral director W. C. Martin & Sons

Address Leonardtown, Md.

19. 10-18-1947 R. V. Dalrymple
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18- 1947, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-16- 1947 to 10-18- 1947 and that I last saw him alive on 10-17- 1947

Immediate cause of death	DURATION
Cerebral apoplexy	
Due to Arterio Sclerosis	
Due to	
Other conditions Gen. debility	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. Dalrymple
M. D. or other

Address Leonardtown, Md. Date signed 10-18-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09354

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County St. Mary's
City or town Bushwood, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County St. Mary's
City or town Bushwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Francis Simpson

3.(b) Social Security Number

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Mary M. Simpson
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): 9-30-1855

8. AGE: Years 92 | Months | Days 18 | If less than one day ... hrs. ... min.

9. Birthplace: Newport Chas. County
(Town, county, and state)
10. Usual occupation: Farming; Retired
11. Industry or business:

FATHER
12. Name: Joseph Simpson
13. Birthplace: Chas. County Md

MOTHER
14. Maiden name: Jane Farr
15. Birthplace: St. Mary's Co. Md

16. Informant: H. Albert Davis
Address: Chaptico, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-20-47 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: Bushwood, Md.

18. Funeral director: Rose E. Welch
Address: Chaptico, Md.

19. 10/18 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 18 1947 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to Oct. 18 1945 and that I last saw h... alive on Oct. 12 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions Arter. Sclerosis. Senility	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank A. Canales M. D. or other
Address Leonardtown Date signed 10/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a

09355

Reg. Dist. No. 284

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

(1)

1. PLACE OF DEATH:

County: St. Mary

City or town: USNAS - Patuxent River, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 hrs

Hospital, institution, or street address where death occurred:
U.S. Naval Dispensary

How long in hospital or institution? 11 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: North Carolina County: Duplin

City or town: Chinquapin - (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Chinquapin
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Wood, William F.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B.(b) Name of husband or wife:

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 22, 1929

8. AGE: Years: 18 Months: Days: If less than one day: hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Seaman

11. Industry or business: Eastern Transportation Co., Baltimore, Md.

FATHER 12. Name: Richard Wood

13. Birthplace: Onslow Co., Verona, N.C.

MOTHER 14. Maiden name: Unknown

15. Birthplace:

16. Informant: E. V. Easter

Address: 1416 Munsey Bldg. - Eastern Trans. Co., Baltimore, Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof 10-20-47 (month) (day) (year)

Cemetery or crematory:

Location: Wallace, North Carolina

18. Funeral director: P. B. Robinson

Address: Leonardtown, Md.

19. Oct 20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19th October 1947, at 6 07 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18th October 1947, to 19th October 1947 and that I last saw h... alive on 19th October 1947

Immediate cause of death	DURATION
Fractures, compound depressed of the skull	11 hrs
Due to: Blow received in fall down the hold of a barge.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 19-October 47

Where did injury occur? USNaval Air Station (City or town) St Mary (County) Maryland (State)

Injured at home, farm, industry, public place (where?): Coal barge - Power Plant

Means of injury: Fall down hold of barge Injured at work? No

23. SIGNATURE: Julian L. Lane Jr. M.D. M. D. or other

Address: U.S. Naval Air Station, Patuxent River, Md. Date signed: 19 Oct 47